DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

Volume 28 Number 18 http://www.dss.mo.gov/dms October 21, 2005

DURABLE MEDICAL EQUIPMENT BULLETIN

CONTENTS

DURABLE MEDICAL EQUIPMENT NOTICE OF RESTRICTED CATEGORIES BENEFITS RELATED TO CROSSOVERS

On November 1, 2005, Missouri Medicaid will implement editing to ensure the correct processing for Medicare/Medicaid Durable Medical Equipment (DME) crossover claims affected by the Senate Bill 539 reduction in benefits. DME crossover claims entering the system on or after November 1, 2005, with dates of service September 1, 2005 and after for individuals enrolled in a reduced benefits category of assistance will follow the same criteria established for the consideration of Medicaid fee for service DME claims. Claims for non-covered DME items will be denied. There will be no retroactive recoveries for any DME crossover claims paid for this reduced benefits category prior to November 1, 2005.

There are three (3) exceptions to this policy:

- Qualified Medicare Beneficiaries (QMB)
  Crossover claims for individuals who are QMB will be considered for payment without regard to the reduction of benefits.

- Home Health Plan of Care
  If the DME item was included under a home health plan of care established and implemented by a Medicare or Medicaid enrolled home health agency, a claim may be filed using the Part B crossover claim form found on eMOMED. The “from” date of the home health certification that would justify payment for this item is required in the appropriate field. The home health plan of care that documents the certification date must be available in the file.

- Nursing Home Residents
  Medicaid recipients residing in nursing homes will be able to use their surplus to pay for crossover claims for federally mandated medically necessary services. This may be done by adjudicating claims through the Medicaid claims processing system to ensure best price, quality, and program integrity.

For details of the reduction of benefits changes, please refer to the July 12, 2005, provider bulletin, "Missouri Medicaid Program Changes" and the September 2, 2005, "Durable Medical Equipment Bulletin".

PRIOR AUTHORIZED SERVICES FOR REDUCED BENEFITS GROUP

Provider Bulletin Volume 27, Number 26 dated July 12, 2005 advised providers of DME changes effective September 1, 2005. That bulletin advised that items of DME that are no longer covered for individuals in a reduced eligibility category of assistance may be covered if the individual is under a Home Health Plan of Care. Some noncovered DME items require prior authorization per Section 19 of the DME Provider Manual. Effective November 1, 2005, prior authorization requests submitted for the noncovered items of DME for individuals in a reduced benefits category of assistance must contain the "from" certification date that is on the home health plan of care. The "from" certification date must be recorded in Section I. (General Information), Field 1. of the Prior Authorization Request form. Prior authorization requests submitted for noncovered items for individuals in a reduced benefits category of assistance that do not contain the "from" certification date in Section I., field 1. will be denied.

HOME HEALTH PLAN OF CARE

A plan of care is considered a home health plan of care only if it is developed and services are provided by a state licensed, Medicare certified and Medicaid enrolled home health agency.

Provider Bulletins are available on the DMS Website at http://www.dss.mo.gov/dms/pages/bulletins.htm. Bulletins will remain on the Published Bulletin site only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896